NJ Department of Health and Senior Services
Cancer Epidemiology Services
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FOR OFFICE USE ONLY	
Accession Number	_____
PHR/Date	_____
HCF Code	_____

NJSCR REPORT FORM

Physician Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Patient Name | **Date of Birth** | **Social Security Number**

Patient Address | **Race/Ethnicity** | **Marital Status** | **Sex**

City, State, Zip Code | **Occupation** | **Industry**

Primary Site/Laterality of this cancer *(attach pathology report)*: _____

Histology Type of this cancer: _____

Date this cancer was FIRST DIAGNOSED: ____/____/____
Month/Day/Year

Initial visit for this cancer: ____/____/____
Month/Day/Year

Most recent visit for this cancer: ____/____/____
Month/Day/Year

METHOD OF DIAGNOSIS
- ☐ Positive histology
- ☐ Positive cytology
- ☐ Autopsy
- ☐ Radiography
- ☐ Clinical
- ☐ Positive lab test marker study

SEER SUMMARY STAGE
- ☐ In situ
- ☐ Localized
- ☐ Regional, NOS
- ☐ Regional by direct extension
- ☐ Regional to lymph nodes
- ☐ Regional by direct extension AND Regional to lymph nodes
- ☐ Distant metastases/systemic disease
- ☐ Unstaged, unknown, or unspecified

TNM CLASSIFICATION
- ☐ Primary Tumor (T)
- ☐ Regional Lymph Nodes(N)
- ☐ Direct Metastasis (M)
- ☐ Stage Group

Did this patient receive any treatment for this cancer? ☐ **Yes** ☐ **No** **If "Yes," please complete the following:**

_____ **Surgery (specify type)** ____/____/____ **Month / Day / Year**

_____ **Radiation (specify type, duration)** ____/____/____ **Month / Day / Year**

_____ **Chemotherapy (specify agents, duration)** ____/____/____ **Month / Day / Year**

_____ **Hormone/Other Treatment (specify type, duration)** ____/____/____ **Month / Day / Year**

Referred to Physician/Hospital: _____
(Provide Name/Address/Telephone Number)

USE BACK OF FORM FOR ADDITIONAL COMMENTS